

July 23, 2015 Industrial Insurance Medical Advisory Committee Meeting

Approved Minutes for Meeting

(*actions taken)

Topic	Discussion & Outcome(s)
Members present: Drs. Bishop, Chamblin, Friedman, Gutke, Harmon, Howe, Lang, Seaman, Tauben, Thielke, Waring Members absent: Drs. Carter, Leveque, Zoltani Clinical expert: Dr. Sverre Vedal (phone) L&I staff present: Gary Franklin, Lee Glass, Leah Hole-Marshall, Teresa Cooper, Hal Stockbridge, Nicholas Reul, Simone Javaher, Jami Lifka, Ian Zhao, Jim Nylander, Zach Gray, Jo Waldschmidt, Barbara Davis Public: Calin Tebay, Juli Yamauchi, Chris Bishop, Mike Ortagan, Ellen Wenzel (phone), Mark Fisher (phone), Josh Artzer (phone)	
Welcome, Introductions, Minutes, Announcements	<p>Dr. Chamblin recognized Dr. Bishop, who is retiring from active practice and from the IIMAC. The new member representing osteopathic medicine, Monica Haines, will be joining the meeting in October. Dr. Chamblin also recognized Teresa Cooper, who is leaving employment with Labor and Industries. This is her last IIMAC meeting.</p> <p>*The minutes were read and approved unanimously.</p>
Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV)	<p>Leah Hole-Marshall updated the committee on the ACHIEV meeting that took place this morning. The membership took a look back at, and gave updates on, their work since the advisory committee was created in the workers' compensation reform legislation. That includes:</p> <ul style="list-style-type: none"> • The Medical Provider Network • Risk of Harm rules • Health Information Exchange • COHE expansion and best practices • Top Tier providers within the network—this project has been on hold, but will restart in October 2015 • Working on the structure of the reports from COHE to the ACHIEV • Quality purchasing and Healthy Worker 2020 • Branding of occupational health best practices <p>Updates and progress on these projects is available at the ACHIEV web page, http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/PNAG/default.asp.</p>
Knee guideline and subcommittee update	<p>The chair asked to present this topic before beryllium, as the meeting was running ahead of schedule and the beryllium discussion was at a scheduled time. Chris Howe, chair of the knee surgery subcommittee, gave an update on the progress of the guideline. The subcommittee has met four times and has made good progress. It can be challenging to determine work-relatedness when osteoarthritis is involved. Dr. Howe shared several highlights: the guideline focuses on the most frequently performed surgeries such as arthroscopic meniscectomy. The KL score is used as a criterion. Will start requiring weight bearing films before allowing surgery. More work is needed on the issue of when repeat surgery is needed. Effectiveness of autologous chondrocyte implantation is questionable; osteochondral autograft is rarely done for acute injury; chondroplasty needs further clarification; all will be discussed at the next subcommittee meeting.</p> <p>Comments: There are new MRI techniques.</p> <p>Suggestion: Change under imaging for meniscectomy—MRI AND X-ray are required.</p> <p>Suggestion: Clarify "return to work" requirement for repeat meniscectomy.</p> <p>Request made to address non-operative care more thoroughly, including use of steroids.</p>

Clinical Guideline for
the Diagnosis of
Beryllium
Sensitization and
Chronic Beryllium
Disease

Dr. Reul presented the clinical guideline for the diagnosis of beryllium sensitization and chronic beryllium disease as it was changed following the April 2015 IIMAC meeting and subsequent additional public comment period. He clarified that the guideline does not create a presumption of coverage. Dr. Sverre Vedal, clinical expert, offered input via the phone and felt this clinical guideline serves its purpose well. He mentioned that the secondary diagnostic pathway is still considered controversial.

Members were interested in the physiological reasons for a false negative BeLPT in the presence of sensitization. Much discussion ensued on smoking, and whether smoking cessation changes the results of the sensitization test; this is not definitively known at this time.

Dianna Chamblin and Leah Hole-Marshall opened the public comment period by explaining the parameters for public comment. Comments came from:

1. Mike O'Hagan, attorney with the Department of Energy. He reminded the department of the letter his agency sent with comments and requests that the department review that.
2. Chris Bishop, attorney with Wallace Klor and Mann. His firm submitted comments in writing and spoke at the last IIMAC meeting. He questions the need for this guideline, as the American Thoracic Society has sufficient information on diagnosis of chronic beryllium disease. He said that the experts at National Jewish Hospital had not participated in the creation of this document. (Dr. Reul later assured him they had significant participation and input). He asked about the prevalence of CBD in Washington. He is concerned about use of patch testing. He asked if the guideline is for diagnosis only and why did we include sections on work-relatedness. He has concerns about the borderline test results and recommends eliminating the secondary diagnostic pathway in favor of recommending consultation with specialists in these cases. Questioned the phrase "strong evidence of exposure".
3. Mark Fisher (on phone), chair of the Beryllium Awareness Group. He said that we need criteria for diagnosis that everyone in the state can follow, as Hanford is not the only site where beryllium is used. He talked about workers having a positive BeLPT at one point, and then "converting" to negative. He has talked with Lisa Meier at National Jewish about this.
4. Josh Artzer (on phone), worker. States he is one of those rare cases where he has both CBD and sarcoidosis, yet has a negative BeLPT test. There is a need for this guideline; it adds clarity for everyone: patients, claims examiners and doctors.

Dr. Reul thanked everyone for their comments and the committee Chair asked him to provide some responses.

Questions and comments from the public:

- The guideline authors did speak with specialists at National Jewish Hospital,
- We don't currently have valid and reliable data on the prevalence of beryllium disease in Washington Workers' compensation due to inconsistencies in coding and system limitations,
- Work-relatedness is mentioned in this guideline because it is a regular part of the department's guidelines, and 3) The department does not require beryllium skin patch testing.

Questions and comments from members:

- How common is the conversion from positive to negative sensitivity testing?
Response: the frequency is not known, but this change is documented in literature. This phenomenon happens with TB skin testing.
- Recommended clarifying that the skin patch test is not recommended.
- Questioned the origin of the secondary diagnostic pathway—it does not appear in other guidelines. Suggested edits further clarifying the rationale and

	<p>the importance and role of specialists when using the secondary diagnostic pathway</p> <ul style="list-style-type: none"> • Recommend adding a past positive BeLPT as an element of criterion b of the secondary diagnostic pathway • Recommend clarifying that tests could have been performed at any time after the exposure • Asked whether the “known scientific evidence” for false negative BeLPT was adequately explained; after discussion, committee agreed this is sufficiently explanatory for users of the document. • Recommended including the citation regarding the influence of immunosuppressive medications <p>The committee voted unanimously in favor of the department adopting the guideline with all the requested changes.</p>
Mental Health Project	<p>Jami Lifka reviewed the progress and work so far on the mental health project, which includes rule changes and changes to our guideline for psychiatric services. The term “psychiatric services” has changed to “mental health services” to be more inclusive of providers and the title is now “Authorization and Reporting Requirements for Mental Health Specialists”. Jo Waldschmidt presented the WHODAS assessment tool that is recommended in DSM 5 and which the department will require, instead of the axis system and GAF scale that was in the DSM-IV.</p> <p>Questions and comments from members:</p> <ul style="list-style-type: none"> • Is the WHODAS available in languages other than English (yes)? • Please give an example of what a narrative describing the WHODAS findings would look like. • Can the WHODAS be built into EPIC or MyChart? • Please post the WHODAS on the L&I website. • Can we add PGAP (progressive goal attainment program) to return to work suggestions? • Please explain or change the phrase “marked changes.”
Tobacco cessation for surgical services	<p>Teresa Cooper presented the new criteria for the department’s payment for tobacco cessation treatment. This will now be covered for any worker having a surgery, not just for spinal fusions. The biggest change from the old coverage decision is the new requirement that patients have a behavioral health component (counseling) as well as a pharmacological product to quit tobacco. Evidence shows that counseling combined with medication is the most effective method currently available. The counseling component can be obtained at a doctors’ or via a telephone hotline or app. IIMAC members had some questions which were addressed. They expressed their support of this decision.</p>
Legislative and L&I announcements	<p>Gary Franklin expressed thanks to everyone who helped with the AMDG opioid guideline and conference. The conference last month was well-received, and the new opioid prescribing guideline is available on the AMDG website. The Bree Collaborative has endorsed the guideline as a standard of care for all providers in the state.</p> <p>Leah Hole-Marshall gave these updates:</p> <ul style="list-style-type: none"> • Introduced Zachary Gray, the new epidemiologist in the Office of the Medical Director. • The Washington legislative session has ended; these are some implications for the Office of the Medical Director: <ul style="list-style-type: none"> ○ We will have a new position to work on risk of harm implementation ○ The bill to create a pilot program to improve care for catastrophically injured workers did not pass, but it is a high-priority project for L&I to improve care. ○ An all-payer claims database was funded; not sure how it will be implemented ○ Other bills were about biological products and telemedicine ○ The Preferred Worker Program passed



Washington State Department of
Labor & Industries

Catastrophic Injury	<p>Nicholas Reul gave a brief presentation on the department's 5-point plan for improving care for catastrophically injured workers:</p> <ol style="list-style-type: none">1. Establish dedicated L&I assignments for catastrophically injured workers (ONC/CM)2. Conduct request for information/request for proposal for external catastrophic care management services3. Establish COHE catastrophic health services coordinator role4. Establish initial Center of Excellence—for Amputee Care5. Design prospective evaluation for catastrophic management
Adjourn	Meeting was adjourned at 5:00.